SEIU Local 1 & Participating Employers Health Trust

DISABILITY CLAIM - SUPPLEMENTARY

This form MUST be completed on or about:_____

PART A: *TO BE COMPLETED BY PARTICIPANT*

1. Personal Information	2. Authorization to release information:
Your Name: _____ Social Security Number:_____ or Alternate ID Number: 825_____ Date of Birth:_____ Address: _____	I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment. I also make claim for benefits and certify that the statements under Part A are true and complete to the best of my knowledge. Signature of Insured Date

PART B: *ATTENDING PHYSICIAN'S STATEMENT*

1. Diagnosis and concurrent conditions:	
2 Frequency of visits: □ Weekly □ Monthly □other:	3. Is patient totally disabled from any occupation? ☐Yes ☐No Date patient became totally disabled:
4. Is patient totally disabled from his/her regular occupation? ☐Yes ☐No Date patient became totally disabled:	5.On what date will the patient be able to resume normal activities and return to work?
6. Attending Physician's Information: Name: _____ Address: _____ Phone: _____ Signature: _____	7. Remarks: Date:

To be completed and signed by the Employer to sign off on last day of work.

Employer Signature Date of Last Day of Work Date Returned to Work

Return completed forms to: SEIU Local 1 & Participating Employers Health Fund, Attn: Disability Dept, 111 E Wacker Drive, 17th Floor Chicago, IL 60601
Phone: (312) 233-8899, Ext 5021 . Fax: (312) 233-8839
Email: SEIUDisability@SEIU25.org